

Compassionate leadership in palliative and end-of-life care

Hewison, Alistair; Sawbridge, Yvonne; Tooley, Laura

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**Compassionate Leadership in Palliative and End-of-Life
Care: A Focus Group Study**

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Compassionate Leadership in Palliative and End-of-Life Care-A Focus Group Study

Introduction

Improving palliative and end-of-life care (hereafter PEOLC) in England is a Department of Health commitment (DH, 2017, 2016, 2008) and NHS England (the executive arm of the English National Health Service) is mandated to deliver on this commitment (DH, 2017). In addition the Ambitions Framework (National Palliative and End of Life Care Partnership, 2015) emphasises the importance of delivering compassionate care, and the NHS Constitution states that:

...we ensure that compassion is central to the care we provide and respond with humanity and kindness to each person’s pain, distress, anxiety or need. We search for the things we can do, however small, to give comfort and relieve suffering. We find time for patients, their families and carers, as well as those we work alongside. We do not wait to be asked, because we care”. (DH, 2015, p5)

The importance of compassion in health care and its impact on staff has been highlighted (Sawbridge and Hewison, 2016, 2015, Hewison and Sawbridge, 2016, Sawbridge, 2016), and there is a link between the quality of patient care and staff well-being (Bridges and Fuller, 2014, Ham, 2014, Maben *et al.*, 2012). Moreover given that ‘compassionate leadership is everyone’s business’ (NHS England, 2014, p. 12), and the Health Care Leadership Model (NHS Leadership Academy, 2013) has been developed for staff in all settings irrespective of whether they have a designated leadership role or not. This is because effective leadership can have a positive impact on patient outcomes (Wong *et al.*, 2013a, Shipton *et al.*, 2008, Firth-Cozens, 2001), and improve staff morale and performance (Wong *et al.*, 2013b, Ham, 2014, King’s Fund, 2012). This in turn suggests examining the nature of leadership in PEOLC would be helpful to illuminate how it can contribute to the provision of compassionate care.

Background and Related literature

It has been made clear at a policy level that effective leadership is essential for the delivery of patient focussed services. For example: ‘Leaders and managers need to create supportive, caring cultures, within teams, within organisations and in the system as a whole, in the way that organisations relate to each other. Leaders at every level have a responsibility to shape and lead a caring culture’ (DH, 2012, p11). The ‘call to action’ to put compassion at the heart of how care is delivered and led is widespread, arising in part from the extensive evidence that demonstrates the link between the quality of patient care and staff experience

is inextricable, and that unless staff are supported quality care is unlikely (NHS, England 2014). Similarly ambition 5 of the national framework for local action 2015-2020 in PEOC, is that all health and care staff bring empathy, skills, and expertise to deliver competent, confident and compassionate care (NPELCP, 2015). Compassionate, inclusive leadership skills for all leaders in health care have been identified as 'critical capabilities' that all organisations and partnerships responsible for NHS-funded activity must develop (National Improvement and Leadership Development Board, 2016). These capabilities include paying close attention to the needs of staff, understanding their situation, responding empathetically and taking thoughtful and appropriate action to help, whilst progressing equality, valuing diversity and challenging power imbalances (National Improvement and Leadership Development Board, 2016). It has been argued that Leadership is the crucial ingredient in improving PEOC and that system leaders should engage with the complexities of healthcare to bring this about (Wee, 2017). The importance of leadership in this field has also been identified in Australia (Keon-Cohen, 2013) and the United States (Kerfoot, 2012). However there are upwards of 400 definitions of leadership (Crainer, 1995) and what leadership means varies hugely dependent on context, which has led some to argue that rather than developing idealised, generic capabilities, leadership development needs to encourage leaders to understand and respond to their particular contexts and enact the skills and capabilities that are required for their situation and time (Turnbull and Ladkin, 2008). In the context of acute hospital care it was found in a recent pilot randomised controlled trial and feasibility study that a workplace educational intervention focused on developing sustainable leadership and work team practices supported the delivery of compassionate care (Bridges *et al.*, 2018). It was concluded that compassionate care interventions should define the role of health-care leaders in mobilising structural capacity to support relational team working of staff in frontline caring roles (Bridges *et al.*, 2018). So rather than relying on organisational models of leadership, the focus on compassion should determine the nature of health care leadership. In order to achieve this Crawford *et al* (2014) recommended that greater use of relevant evidence would enable clinical leaders to optimise the use of warm, compassionate interactional styles of leadership, even when under pressure. Similarly Curtis *et al* (2017) found that supportive leadership was instrumental in cascading a culture of compassion to peers and colleagues. In recognition of the importance of developing compassionate organisations the National Forum for Health and Well-being at Work (2017) produced a 'toolkit' designed to ensure that leaders, and staff more generally develop their social and interpersonal skills of empathy and compassion to enhance their own and others' wellbeing,

for the good of the organisation. There is evidence that this has a direct impact on staff in palliative care settings and can reduce compassion fatigue (West *et al.*, 2017). Based on their findings MacArthur *et al* (2017) contend there is need for a strategic vision for compassionate care that recognises and values the role of relationships and invests in practice development and leadership at all levels, however they concede that the components of the organisational infrastructure needed to embed and sustain compassionate care amidst all the other health service pressures and priorities, are less clear.

This suggests our understanding of how leadership is enacted in different settings needs expanding and unless this is done much actual leadership activity will go unrecognised or undeveloped, and organisations will focus on traditional leadership behaviours which are not appropriate for current challenges (Turnbull-James, 2011), rather than compassion. In view of this if compassionate leadership is to be realised there is a need to explore what it means in the context of PEOLC, and in order to do this it is important to listen to the first-hand experiences of staff (DH, 2014). The overall aim of the study was to explore compassionate leadership with those involved in leading end-of-life care in a range of settings. The intention was to identify current compassionate leadership activity and explore the experience of staff leading PEOLC.

The objectives were:

- To define compassionate leadership in the context of end-of-life and palliative care;
- To collect accounts of compassionate leadership activity from key stakeholders in end-of-life and palliative care;
- To identify examples of compassionate leadership in practice;

Methods

As little is known about how compassionate leadership is being conducted in PEOLC, a qualitative, approach to its investigation was deemed to be the most suitable to achieve the objectives of the project, by providing rich, in-depth data, and allowing for new knowledge production (Miles *et al.*, 2013). The plan was to conduct three focus groups in order to access the accounts of staff involved in leadership in PEOLC in the West Midlands of England. The coordinator of an existing network of health professionals working in PEOLC invited

expressions of interest from members working in a range of organisations/settings to identify a purposive sample of respondents (Kuzel, 1992, Teddlie and Yu, 2007). Focus groups were appropriate for this study because through involving participants in the group process, they are enabled to explore and clarify their views in ways that would be less easily accessible in a one to one interview (Kitzinger, 1995). They also facilitate the expression of ideas and experiences that might be left underdeveloped in an individual interview and illuminate the participants' perspectives through debate in the group (Kitzinger, 1995, 1994). Through active discussion of issues, participants reveal more of their own frame of reference (Finch *et al.*, 2014). In addition to the collection of rich data, this approach also helps ensure that a variety of perspectives are sought on the issue being explored (Ritchie *et al.*, 2013). This was necessary to build a comprehensive account of leadership in PEO LC. Ethical approval for the study was confirmed by the University of Birmingham Research Ethics Committee (ERN_17-0333).

Findings

In excess of 300 staff from across the West Midlands of England were invited to participate in a focus group. Thirty one expressed an interest and were offered a range of dates to attend a focus group. In the event 14 participants attended (see table 1 for details).

(table 1 here)

The focus groups lasted between 46 and 70 minutes and were moderated by two researchers. The data were collected during the four focus groups which were audio recorded and transcribed verbatim to facilitate detailed analysis. Although initially three focus groups were planned, in an effort to encourage maximum attendance additional opportunities were offered on a range of dates. The questions used to prompt discussion in the focus groups can be found in figure 1.

(figure 1 here)

The data were analysed thematically in line with the principles of Porter's cyclical approach involving identification of patterns, consideration of variations and limitations, explanation of patterns and building explanations (Porter, 1996). Each transcript was read several times line-by-line. In view of the relatively limited data set a 'pen and paper' approach was undertaken involving colour highlighting of key sections of the text and margin notes to develop the codes. Codes were assigned to notable extracts that signified key issues in the data (Miles

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3 and Huberman, 1994). These were then reviewed and grouped into categories reflecting the
4 main areas and concerns addressed by the participants, and ultimately synthesised into
5 themes (Strauss and Corbin, 1998, Charmaz, 2006). Two members of the team
6 independently coded the data and met to discuss the outcome and agree the final themes.
7
8 Table 2 includes an example of an element of the coding process for one of the themes. The
9 themes are presented below. Illustrative data extracts are labelled by participant and focus
10 group. The focus group numbers have been reordered to account for the non-attendance at
11 focus group 2 (see table 1).

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19 (table 2 here)
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23
24 **Leadership in palliative and end-of-life care**

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26 *Generic Leadership*

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28 The participants engaged in wide ranging discussions of the nature of leadership. These have
29 been characterised as ‘generic’ because they reflect a number of key principles that are
30 evident in the literature and existing leadership models (Huczynski and Buchanan, 2013,
31 Mullins, 2010, NHS Leadership Academy, 2013). For example they spoke of leadership in
32 general terms as ‘showing the way’ (P1, FG2), and made statements such as ‘...having the
33 responsibility and taking the responsibility to make a decision with a broader vision...’ (P3,
34 FG 3). The leader as a role model, the different levels of leadership and the importance of
35 consistency and good communication were also referred to. These elements are not explored
36 in detail here because excellent summaries of the key components of healthcare leadership
37 have already been produced (see for example-NHS Leadership Academy, 2011, King’s Fund,
38 2017, 2012, 2011). Rather the aim was to explore the nature of compassionate leadership in
39 PEOLC and so the focus of the analysis below reflects this.

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49 *Everyone has a story*

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51 The participants were asked to consider the nature of leadership in PEOLC. They felt it was
52 important to recognise that everyone who works in PEOLC ‘has a story’ (P1, FG 4). For
53 example ‘My story was the death of my Mum and I was finding out more about how to help
54 people in that situation.’ (P1, FG4). The participants agreed that there was something
55 distinctive about working in PEOLC that is ‘a way of being’ (P1, FG2). For example:
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‘You’ve got to want to be in palliative care for whatever reason that is. I wouldn’t say it’s universal, it probably isn’t but most people I’ve come across have got some story to tell.’ (P2, FG4)

This was also seen as a privilege to an extent with one respondent stating ‘we are blessed to do what we do’ (P3 FG 3). This affinity with PEOLC was reported to shape the approach to leadership taken by the participants. It was recognised that working in PEOLC was extremely demanding, as summarised in the data extract below:

‘...it’s a big emotional burden, so I say yes this is the burden you swap. You don’t have the busyness of running around an acute medical ward that you used to have but you have this huge emotional burden of watching people suffer terribly, watching tragedy most days and having to deal with that and having to go into that situation and try your best to do what we can to make it better’ (P1, FG1)

This common experience provided a unifying element, in the participants’ teams, and indeed it was noted that most of the participants-although drawn from a wide geographical area-knew most of the people working in the field, and attributed this to the ‘way of being’ noted earlier and a shared understanding of the nature of the work. This was felt to shape their approach to leadership and how this was demonstrated is explored below.

Leadership as challenge

The participants felt a key part of their approach to leadership was to challenge others. For example, ‘...leadership is to be able to provoke a reaction in anybody that’s around you in a good way.’ (P1, FG2). Similarly ‘I think being compassionate isn’t always about saying “there there it’s okay”, but it’s about being able to challenge something’, and this respondent went on to make a link that was echoed in the other groups ‘...and having the confidence to, and being empowered to actually be able to do that is something that we are only just working towards to actually be compassionate and challenge staff...’ (P3 FG3). The importance of challenging staff to develop solutions to problems and promote their own ideas about how to improve practice was discussed at length. It was regarded as a crucial element of leadership. However it needed to be balanced with support and the terms ‘empowerment’ and ‘nurturing’ were used repeatedly by the respondents to convey the need for both challenge and support in their leadership role. This was necessary to encourage staff to feel comfortable in exploring new approaches to PEOLC. For example:

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3 'I think to get the best out of people, you've got to show compassion to your staff and
4 support them and they will flourish and feel free to be actually quite creative in their
5 thinking and quite free to engage with patients in perhaps different ways with new
6 ideas.' (P1, FG 1)
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9 This is not to suggest that all of the areas respondents worked in reflected this approach.
10 Indeed there were some accounts of situations where there was little support and staff felt
11 isolated and under pressure. In some cases this was because of the 'target culture' and the
12 need to achieve evermore stringent metrics. In others it was attributed to a failure in
13 leadership. For example when one respondent reported how she and her colleagues were
14 discouraged from discussing distressing deaths of the children they cared for by her line
15 manager, another participant commented: 'So that's a complete lack of empathy actually in
16 your leadership that you report to' (P2 FG3). Where support and empathy were demonstrated
17 it was generally a combination of personal engagement and team processes focussed on the
18 needs of team members. The links between compassionate leadership and innovation
19 identified by the respondents has also been highlighted in recent work by West et al (2017)
20 who found: Compassionate leadership creates the necessary conditions for innovation among
21 individuals, in teams, in the process of inter-team working, at the level of organisational
22 functioning as a whole, and in cross-boundary or systems working (p5). This emphasises the
23 importance of building an understanding of compassionate leadership in a range of settings.
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36 *Permission to be human*

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38 Knowledge of team members and an understanding of their circumstances was central to the
39 provision of support to staff. For example:
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42 'I think in order for you to go and deliver that compassionate care...it's almost like
43 you need to receive that as well to enable you to go and do that with patients. So it's
44 that little bit of understanding, that flexibility, that sort of coming from a different
45 angle with the staff.' (P4 FG3)
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48 This involved helping staff to develop their resilience, confidence and skills of reflection in
49 order to support them in managing the emotional work inherent in PEoLC. This in turn
50 required that leaders were skilful in balancing the individual needs of team members and the
51 work of the wider team or organisation:
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55 'I think for me that one of the biggest roles of leading however you do, is to give
56 people permission to be human and it's not the same as not being aware of
57 professional boundaries you have, but it's to acknowledge that we're both
58 professionals and human beings (P2 FG 3)
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The respondents reported cases where staff had complex and demanding family situations, involving illness and bereavement for example, which meant they needed support and time away from work. This also entailed being sensitive with work assignments, for example a case of a staff member who had experienced a still birth yet insisted on attending a paediatric CPR course was shared in one of the focus groups. The respondent explained how careful discussion took place to ensure the staff member had considered how this might affect her, and was given permission to withdraw if it became distressing. In another instance a staff member who had been bereaved was not given permission to return to work from compassionate leave by her manager. The manager (a respondent) explained that the staff member was 'not ready', and although the individual concerned was angry at the time she later accepted that this was the correct decision, taken in her best interests.

With regard to team and/or organisational activities that recognised the 'human' needs of staff and were reported as being supportive, some are identified in the 'best practice' examples (see below), others included social functions to engender a spirit of team-working and mutual support. Celebration of 'significant' birthdays and other important life events (births, marriages and so on) were felt to be particularly important as recognition of colleagues having lives and demands outside the work setting. Any activities intended to create a 'culture of care' were felt to be evidence of compassionate leadership. This involved building trust by having 'nice' coffee in meetings and giving people time to discuss issues of concern for example, which demonstrated care for the team. Emphasising to staff that they could always call a manager to discuss any challenging clinical issues, and good senior manager support were also identified. It was felt compassionate leadership was evident when team members were aware of the needs of each other and did not need prompting to offer/provide support and encouragement. Senior managers retaining some sort of contact with practice so that they were aware of the pressures/demands on staff, and acceptance of the emotional demands of the work by all those involved were also cited as features of a culture of care.

Managing boundaries

The complex nature of PEOLC presents some particularly challenging leadership issues with regard to managing boundaries. The respondents discussed how enabling staff to manage boundaries with patients and families was essential. The nature of PEOLC means that in

order to provide good care staff have to build close relationships with patients and families.
For example:

‘You can’t do your job without developing a relationship but there is a line and making it really clear you do not cross that line’ (P 3 FG2)

Managing the boundaries of where the professional relationship and personal involvement overlap was challenging for staff, particularly those new to PEOLC. This was of concern when patients’ family members continued to visit staff for support during their bereavement following a death.

‘...we have to let go somewhere, we have to draw a boundary and we have to remember we are there to be friendly doctors, not a friend...for newer team members it is a case of guiding them as to what they should and shouldn’t do, to protect themselves as well, because whilst we want to be kind and supportive, we can’t be there for them all the time...’ (P1, FG1)

Other difficult situations included ensuring that staff attendance at patients’ funerals was proportionate and consistent (e.g. avoiding situations where several staff went to one funeral and none to another). Another boundary that leaders had to be mindful of was that between ‘being human’ and being professional with staff. In order to provide compassionate leadership the respondents reported they had to know their staff, demonstrate empathy to them, and be aware of their circumstances. However it was sometimes challenging to balance understanding the team members’ needs and being seen to be prying into their personal life. The respondents also felt a sense of responsibility in terms of ensuring their staff were well, and were aware this raised boundary issues related to their own professional expertise and experience. ‘...I can talk to patients but I am not a trained counsellor and it was important that I knew my boundaries too’ (P1, FG1).

On a personal level the respondents reported how continually working with people who died raised issues of their own mortality and that of their families and friends which had to be worked through and resolved. This presented difficulties with regard to managing the boundary between their own practice and personal feelings of vulnerability and loss, particularly when a family member or friend had died recently. This underlines the need for leaders in PEOLC to be skilled, empathic communicators, who understand their own feelings and those of others, and a concern was expressed that this may be a problem in the future. The need for emotional resilience on the part of leaders and indeed all those working in PEOLC was identified as essential.

‘We don’t prepare the people that are coming after us to have emotional strength and intelligence to negotiate with the difficulties of end-of-life.’ (P1, FG2)

One of the aims of the focus group study was to identify best practice examples of compassionate leadership in PEoLC. The examples discussed by the participants are summarised below:

Examples of Compassionate Leadership in Practice

In the course of the focus groups the participants reported examples of best practice with regard to supportive and compassionate leadership in PEoLC. These included:

- Anonymous independent Counselling sessions (up to four) paid for by the organisation. A similar arrangement had been introduced in another organisation with six sessions paid for. These were open to all staff.
- Independent telephone helpline for staff available 24/7, 365 days of the year;
- Debriefing sessions following ‘difficult’ end-of-life cases/experiences;
- ‘Listening into Action’ exercises focussed on end-of-life care were reported in two organisations;
- Supervision-several respondents reported the benefits of monthly supervision. As one respondent characterised the supervision sessions- they constitute ‘preventative medicine’ for staff. The opportunity to meet and discuss the challenges of end-of-life care was universally endorsed by the respondents;
- Email/text support for staff in community (lone workers);
- Team bonding activities;
- Leadership development for the team;
- Multi-disciplinary meetings-the Chair ‘rotates’ and the meeting is a forum for discussion of staff concerns and feelings as well as clinical issues.

Discussion

It has been noted that compassion is ‘having a moment’ in contemporary palliative and end-of-life care discourse, although there is a need for caution if unrealistic expectations about its potential are to be avoided because there are difficulties for compassion to flow freely, particularly within Western society (Zaman *et al.*, 2018). Although the number of participants in the study was low, this is more a reflection of the nature of their work pressures and difficulties in securing time to attend the focus groups rather than a lack of

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willingness to take part. Those who did participate reported accounts of what they felt compassionate leadership entailed and acknowledged the organisational challenges involved in achieving it. Consequently if the NHS requires a fundamental shift from pace-setting leadership styles to participative and facilitative ways of working (King’s Fund, 2017), and compassion, respect and humanity from frontline staff need to be better supported and engendered by a leadership community that holds these qualities as central to the core mission and purpose of the NHS (Storey and Holti, 2013), then the key components of compassion-attending, understanding, empathising and helping (Atkins and Parker, 2012)- must be demonstrated by NHS leaders through their leadership of health care organisations, at every level (West and Chowla, 2017). Indeed it is known that caring for dying patients is part of the core business of acute hospitals (Mayland *et al.*, 2017) and that the number of deaths in NHS hospitals is likely to increase by 19%, from 310 815 per year in 2003 to 369 810 per year in 2030 (Gomes and Higginson, 2008), so the need for compassionate leadership in PEOLC is a wider system concern. **The findings presented here provide further evidence of the need for such an approach.**

This form of leadership can be related to relational approaches such as servant leadership which emphasises the importance of empathy, awareness of staff needs, commitment to the growth of people, and building community, as key to taking care of people who provide care (Waterman, 2011, Neill and Saunders, 2008). **It also shares some common ground with resonant leadership enacted by leaders who know and can communicate what to do and why to do it and demonstrate compassion by being aware of the needs of people and responding to those needs authentically (McKee and Massimilian, 2006).** There is evidence that organisational interventions to support the development of compassionate practices can have a positive impact on patient care (Curtis *et al.*, 2017, Robert *et al.*, 2017, Dewar and Nolan, 2013, Gould *et al.*, 2018; Bridges and Fuller, 2014). However such interventions may be not be possible for all health care organisations and developing collective leadership in organisations depends crucially on local contexts and is best done ‘in house’ with expert support , integrating organisational and leadership development (West and West, 2015). It also involves acknowledging and making provision for the difficulties and challenges of working in an anxiety-laden context (de Zulueta, 2016), which was recognised by the participants in the present study. It has been argued that there is a need to support and encourage internal structures that will allow a habitus of compassionate care to flourish (Goodman, 2013) and that tasks and relational care need to be integrated into a coherent

unity, creating space for dialogue between patients, clinicians, and managers, so that together they can co-create ways to flourish in the context of illness and dying (de Zulueta, 2016). For example it has been found that when there is authentic leadership and fulfilment of a vision of providing good palliative care is realised, it can serve as a buffer against the stress of working in a palliative care unit (Johansson *et al.*, 2010). Authentic leadership in this context being ‘true to oneself’ (Wong and Cummings, 2009) and focussed on the leader’s relationships with others (Avolio and Gardner, 2005). This relational leadership approach can improve outcomes for the nursing workforce and their work environments (Cummings *et al.*, 2018) and also has benefits for leaders in terms of developing feelings of empowerment and wellbeing (Cardiff *et al.*, 2018). The approach offers a vision of leadership as a collaborative endeavour, involving the management of complex relationships between internal and external stakeholders through informal processes (Freeman, 2013). Relational leadership draws on an intersubjective view of the world and offers a way of thinking about who leaders are in relation to others and how they might work with others within the complexity of experience—in sum it means recognising the entwined nature of our relationships with others (Cunliffe and Eriksen, 2011). Whilst some have questioned the premise of authentic leadership (Ford and Harding, 2011), a relational approach to leadership has been advocated to improve decision making (Fulop and Mark, 2013), improve safety (Thompson *et al.*, 2011), and promote service improvement (Fitzgerald *et al.*, 2013), **and resonant leadership as a form of relational leadership, has been found to lower patient mortality and improve nurses’ health, job satisfaction, organizational commitment, emotional exhaustion, and intent to stay in their position (Spence Laschinger et al., 2014).** Its focus on creating positive relationships with others based on a relational self-identity incorporating an ‘other-orientation’, that is an orientation toward meeting the legitimate needs of others (Anderson and Sun, 2015), resonates with the accounts of the respondents in the focus groups and suggests this approach is appropriate for leadership in PEO LC. It is also, perhaps, an approach that many working in this field would adopt given that relational approaches to patient interaction have been associated with the delivery of compassionate care (Murrells *et al.*, 2013; Bridges *et al.*, 2017; Dewar and Cook, 2014). It offers a way of reconceptualising relationships between leaders, organisational members and other stakeholders as an ongoing subjective shaping of social circumstances (Cunliffe and Eriksen, 2011, p.1455). **In summary, in terms of leadership, compassion is more than relevant, it is integral (McKee and Massimilian, 2006).**

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The need for leadership in PEOLC to be given much greater priority throughout the health and care system has been identified (NCPC, 2015), and the distinct features of PEOLC leadership reported here can inform leadership development in teams to help ensure it focusses on the context specific nature of leadership in these settings and health care more generally. Although comprehensive guidance documents have been produced to assist organisations in developing such approaches (see NHS Improvement, 2017, for example), leadership development needs to be deeply embedded in and informed by the context and the challenges that leaders in the organisation face collectively in the specific organisation context and requires conversations and learning with people who share that context (Turnbull-James, 2011). This can be achieved using action learning, an approach which has been effective in developing leadership skills in PEOLC (Gillett *et al.*, 2017, Hewison *et al.*, 2011).

Conclusion

The data demonstrate that there are aspects of leadership in PEOLC that are context specific and shaped by the particular experiences of the people drawn to work in the field. A sensitivity to the needs of staff, which is a feature of all good leaders, is even more important in PEOLC given the heightened emotional content of the work. The accounts of the participants provided examples of where this works well, and the problems that ensue where it is less well developed. The management of boundaries was also identified to be a concern and indicates another defining feature of leading PEOLC. This suggests leadership needs to be understood in terms of its practices and organisational interventions, not just personal behavioural style or competences and that the focus should be on organisational relations, connectedness, interventions into the organisational system, and changing organisational practices and processes (Turnbull-James, 2011). The practice examples identified by the participants indicates that compassionate leadership is being enacted in many health care organisations, however if it is to be embedded across all areas involved in the delivery of PEOLC it will involve caring for others, helping them grow and develop and giving them the freedom to explore and experiment so that they can challenge the status quo and be innovative (West *et al.*, 2017). This is the challenge for health care organisations in England and elsewhere if staff are to be retained and compassionate patient care provided.

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Leadership in Health Services

Table 1: Focus Groups

Focus Group	Attendees	Roles
1 (1)	1	Medical Consultant in Palliative Care, Hospice
2	Nil	
3 (2)	5	Specialty Doctor, Hospice Lead Nurse, Acute Hospital Medical/Palliative Consultant, Acute Hospital Service Lead, Acute Trust Community Service Lead, Hospice
4 (3)	6	Clinical Psychologist, Acute Trust Macmillan Lead Nurse, Acute Trust Counselling Psychologist, Acute Trust Education and Development Lead, Hospice Operations Manager, Specialist Palliative and End of Life Care Services, Acute Trust Senior Nurse, Specialist Palliative and End of Life Care Services, Acute Trust
5 (4)	2	Specialist Palliative Care, Clinical Nurse Specialist, Acute Trust Director of Care Services, Hospice
Total	14	

Table 2: Theme development

Codes	Theme
Examples of key words phrases that were grouped into categories to inform the theme.	Everyone has a story
I often tell them a story about... I like stories	
I tell them the story about a situation we had on our ward	
telling them the story of the team	
I think it's knowing what's going on in the back story	
I don't really know the full story yet	

Category

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Figure 1: Focus Group Questions

1. Introductions, restatement of purpose of the interview. Confirm consent.
2. When we talk about leadership in health care what do you think it means?
3. How is compassion defined/understood in your area?
4. How would you define compassionate leadership? Are they compatible?
5. Can you share some examples of what you would consider to be compassionate leadership?
6. Are there any particular elements that make compassionate leadership different to leadership in general?
7. What would you consider to be best practice examples of compassionate leadership?
8. Are there any particular challenges involved in leading in palliative and end of life care?
9. Does compassionate leadership improve standards of care? How?
10. Does compassionate leadership improve staff support? How?
11. Do you feel adequately supported to provide compassionate leadership?
12. Do you think there is a need for a forum for leaders in palliative care to meet and share ideas about leadership?
13. Would you be interested in participating in such a forum? Do you think there would be interest from colleagues where you work?
14. Is there anything else you think it would be helpful for us to know about?

Any other comments?